

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12830

12825

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 69 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		d. STREET ADDRESS 410 High Street	
3. NAME OF DECEASED (Type or print) First Middle Last Emma Lillian Baker		4. DATE OF DEATH Month Day Year 9 10 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 1/3/1884
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? IN US	
13. FATHER'S NAME Charles Hessner		14. MOTHER'S MAIDEN NAME Augusta Hamilton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-9729	
17. INFORMANT Hospital Records		Address Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complications of old age DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/3 , 19 66 , to 9/10 , 19 66 , that (I) (we) last saw the deceased alive on 9/10 , 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Dr. A. C. Dick		22b. DATE SIGNED 9-10-66	
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Dick		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/13/66	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City or Town) (County) (State) Galena Maryland	
24. FUNERAL DIRECTOR J. Wells Wells		25a. REC'D BY REGISTRAR DATE SEP 14 1966	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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RECEIVED OF DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12826

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Morris First A. Middle Bratcher Last				4. DATE OF DEATH Month 9 Day 14 Year 66			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/3/1912	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 5 Days 4		IF UNDER 24 HRS. Hours 5 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Steve Bratcher				14. MOTHER'S MAIDEN NAME Elizabeth Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-18-2865		17. INFORMANT Randolph Johnson Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hypertensive cardiovascular renal disease</p> <p>492X DUE TO Hospitalized several times in the past 3 years</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) in states of congestive failure and impending renal failure. Found dead in his room about noon on the day of death, Had been dead about 5 or 6 hours</p> <p>(c) on the day of death, Had been dead about 5 or 6 hours</p> </div> <div style="width: 65%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) May have had digitalis intoxication</p> </div> </div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Robert W. Farr</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/1966		22c. NAME OF CEMETERY OR CREMATORY James Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles Judge</i>				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE SEP 12 1966	
						24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13856

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13856

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10/15/1910		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Residence		Social History	
Myocardial Infarction		Natural		Teacher		123 Main St, Boston		No Alcohol, No Tobacco	
Time of Death		Place of Death		Physician		Hospital		Burial Place	
10:30 AM		Home		Dr. Smith		St. Mary's		Catholic Cemetery	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
13856

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Millington				c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 402 Calvert Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Reuben First O. Middle Cannon Last				4. DATE OF DEATH September 29 19 66			
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/23/41	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer - various				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent county	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert D. Cannon				14. MOTHER'S MAIDEN NAME Edna Dickerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217 36 1548		17. INFORMANT Edna Dickerson 402 Calvert St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown but natural causes DUE TO Probable cardiac Was hypertensive and over weight. Became very edema- tous two to three weeks before death. Had syncopal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. attack about 2 weeks prior to death. Banged on wall 7:45 on date of death & was observed to take 3 or 4 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) breaths and died.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/3/1966		22c. NAME OF CEMETERY OR CREMATORY JANES CEMETERY		22d. LOCATION (City, town, or county) (State) Chestertown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Benneth Wall				ADDRESS Chestertown, Md		24a. REC'D BY REGISTRAR DATE OCT 5 1966	
				24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12833

CERTIFICATE OF DEATH

12828

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barclay		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital					d. STREET ADDRESS Rt. #1 Box 39		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ellsworth Vanleer Conover				4. DATE OF DEATH Month 9 Day 14 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/1909		9. AGE (In years lost birthday) 56 Yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (County & State, or foreign country) Camden Co., N.J.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Walter Conover				14. MOTHER'S MAIDEN NAME Frances Goldy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 137 18 4147		17. INFORMANT Hospital Redords Chestertown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery embolus DUE TO (b) Plaque DUE TO (c) Plaque Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 10 minutes 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/9/66 , 19__, to 9/14/66 , 19__, that (I) (we) last saw the deceased alive on 9/14 , 19 66 , and that death occurred at __ M, from causes and on the date stated above.							
22a. SIGNATURE Dr. A. C. Dick				22b. DATE SIGNED 9-14-66		22c. PHYSICIAN'S NAME (Type) Dr. A. C. Dick	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/17/66		23c. NAME OF CEMETERY OR CREMATORY New St. Mary's		23d. LOCATION (City or Town) (County) (State) Bellmawr, N. J.	
24. FUNERAL DIRECTOR Charles Judge				25a. REC'D BY REGISTRAR DATE SEP 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED BY MAIL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Millington</u>			c. LENGTH OF STAY IN 1b <u>1 Yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Millington</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peacock Convelesent Home</u>					d. STREET ADDRESS <u>None</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Davis</u> Last <u>Davis</u>			4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4, 1898</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>					14. MOTHER'S MAIDEN NAME <u>No Record</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Doris Boone Millington, Maryland</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Progressive paralysis</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1957</u> to <u>Sept 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 8, 1966</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Geza Koralewski</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u> 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-12-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u> 23d. LOCATION (City, town or county) (State) <u>Marydel, Maryland</u> 24. FUNERAL DIRECTOR <u>J.E. Boula's Greenlboro, Md.</u> ADDRESS <u>J.E. Boula's Greenlboro, Md.</u> 25a. REC'D BY REGISTRAR <u>SEP 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. Or: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT COUNTY, MD MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. WORTON, MD</u>		c. LENGTH OF STAY IN 1b <u>3-YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER TOWN, MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FREEMAN NURSING HOME, WORTON, MD</u>				d. STREET ADDRESS <u>R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>FORD</u> Last <u>FORD</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>10</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/5/1885</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VARIOUS</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES RASIN</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE FREEMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. Mildred Towson Chester Town, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>Had been invalid for a number of years. Was in nursing home 4½ years at time of death. Said to have</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>suffered from heart trouble. Died 7:30 P.M. 9/10/66</u>							INTERVAL BETWEEN ONSET AND DEATH <u>several</u> years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>CHESTER TOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/14/1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. PISGAH CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>R.F.D. Chester Town, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u>				ADDRESS <u>Chester Town, MD</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12836						CERTIFICATE OF DEATH			12831				
1. PLACE OF DEATH a. COUNTY <u>Kent Co.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesterstown</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Kent & Queen Anne's Hospital, Inc.</u>						d. STREET ADDRESS <u>Box 14</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET Josephine HARTMAN</u>						4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-23-1915</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>JAMES BAKER</u>						14. MOTHER'S MAIDEN NAME <u>MARY MATILDA HARPER</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-52-7923</u>		17. INFORMANT <u>Hospital Records</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> 3403 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>CK Phth. from Houty</u> <u>Disty med. - Kent County</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fragile heart</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell at home</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> a.m. <u>9:17</u> p.m. <u>1966</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rock Hall Kent Md</u>					
21. I certify that (I) (this hospital) attended the deceased from <u>9-17-1966</u> to <u>9-23-1966</u> , that (I) (we) last saw the deceased alive on <u>9-23-1966</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Arthur T. Keefe</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9/26/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Arthur T. Keefe</u>						22d. ADDRESS <u>Chesterstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Rock Hall, Md.</u>					
24. FUNERAL DIRECTOR <u>William Wells</u>						ADDRESS <u>Chesterstown, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>SEP 27 1966</u>			25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

15291

15291

TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12837					12832						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY Kent					a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown					b. COUNTY Kent						
c. LENGTH OF STAY IN 1b 45 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (Rural)						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Kent & Queen Anne's Hospital, Inc.					d. STREET ADDRESS 14-1						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Susie Elsie Lamb			4. DATE OF DEATH Month 9 Day 14 Year 1966								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/16/1891		9. AGE (In years last birthday) 75 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kent County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Lewis Hyland Price VanZant					14. MOTHER'S MAIDEN NAME Elizabeth Emily Jarvis						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. none						
17. INFORMANT Hospital Records					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous, generalized 1992 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1966		20f. (County) 9-14			
21. I certify that (I) (this hospital) attended the deceased from 6-10 , 19 66 , to 9-14 , 19 66 , that (I) (we) last saw the deceased alive on 9-14-66 , 19 66 , and that death occurred at 7p M, from the causes and on the date stated above.											
22a. SIGNATURE A.C. Dick					22b. DATE SIGNED 9-14-66		22c. PHYSICIAN'S NAME (Type) A.C. Dick				
22d. ADDRESS Chestertown, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/17/66		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE William Wells					25a. REC'D BY REGISTRAR DATE SEP 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

15831

15831

Hydrog. columnaris

Acid

A. C. Dick

Chlorostoma n. M.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12833

12833

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Pearl NMN Lee		4. DATE OF DEATH Month Day Year 9 30 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1908
9. AGE (in years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Sorter- Campbell Soup		12. KIND OF BUSINESS OR INDUSTRY Penn.	
13. BIRTHPLACE (County & State, or foreign country) Penn.		14. CITIZEN OF WHAT COUNTRY? US	
15. FATHER'S NAME Frank Oscar Smeal		16. MOTHER'S MAIDEN NAME Elva Etta Narehood	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO. 143-01-3732	
19. INFORMANT Hospital Records		Address Chestertown, Maryland	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bacterial valvulitis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/27 , 19 66 , to 9/30 , 19 66 , that (I) (we) last saw the deceased alive on 9/30 , 19 66 , and that death occurred at 11:00 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Dr. Robert W. Farr		22b. DATE SIGNED 9/30/66	
22c. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/2/66	23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemete y	23d. LOCATION (City or Town) (County) (State) Greensboro, Md.
24. FUNERAL DIRECTOR J. Willis Wells ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE OCT 4 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

13833

STATE OF TEXAS

13833

Name		Last	
First		Middle	
Address		City	
State		Zip	
Occupation		Education	
Marital Status		Date of Birth	
Social Security Number		Date of Issue	
Signature		Date	
Witness Signature		Date	
Notary Signature		Date	
Notary Seal		Notary Commission Expires	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12839

CERTIFICATE OF DEATH

12834

1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN c. LENGTH OF STAY IN ID 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENT & QUEEN ANNES HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall, Maryland d. STREET ADDRESS 14-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) RALPH NICKERSON MCGINNIS		4. DATE OF DEATH Month 9 Day 20 Year 1966		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1/17/1895		9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pk Mgr. Tolchester		11. BIRTHPLACE (County & State, or foreign country) Queen Anne's, Maryland		12. CITIZEN OF WHAT COUNTRY? American					
13. FATHER'S NAME THOMAS MCGINNIS				14. MOTHER'S MAIDEN NAME ELLA STARTT				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 216-18-2400				17. INFORMANT Joyce B. Grean				18. ADDRESS Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 260X DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) DIABETES MELLITUS MILD																		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MUOCARDIAL DECOMPENSATION CHRONIC + ACUTE																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-14 , 19 66 , to 9-20 , 19 66 , that (I) (we) last saw the deceased alive on 9-20 , 19 66 , and that death occurred at 4:15 PM , from the causes and on the date stated above.																							
22a. SIGNATURE Harry P. Ross												22b. DATE SIGNED 9-22-66		22c. PHYSICIAN'S NAME (Type) HARRY P. ROSS				22d. ADDRESS CHESTERTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/24/66				23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.				23d. LOCATION (City, town or county) (State) Rock Hall, Md.											
24. FUNERAL DIRECTOR J. Willis Wells												25a. REC'D BY REGISTRAR SEP 26 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge									

12234

12234

Unit

Marshall

Rock Hill, Maryland

Marshall

Queen Anne's, Maryland

Marshall

Marshall

Marshall

Marshall

Marshall

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at home Kent St. extended		d. STREET ADDRESS <div style="text-align: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
3. NAME OF DECEASED (Type or print) Francis Theodore Needles		4. DATE OF DEATH Month Sept. Day 18, Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 1, 1926
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tester for C. P. Telephone Co.		10b. KIND OF BUSINESS OR INDUSTRY Chestertown, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Horace V. Needles		14. MOTHER'S MAIDEN NAME Frances Bacon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 11		16. SOCIAL SECURITY NO. 215 20 0160	
17. INFORMANT Mrs. Jane Needles		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 22 caliber revolver wound in side of head 976K Wound of entrance in it temple - no exit DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH none	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted	
20c. TIME OF INJURY Month, Day, Year 9-18-66 9/18 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Chestertown (County) Kent (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		DATE SIGNED 9/18/66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/66	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 22 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12848					12836				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)				
a. COUNTY		Kent			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Chestertown			b. COUNTY		Kent		
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Chestertown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
at home (Morgnec)					Morgnec		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Middle Last			4. DATE OF DEATH		Month Day Year		
Thomas Laurence Peterson					Sept. 15, 1966		19		
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED		8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	<input checked="" type="checkbox"/>	<input type="checkbox"/>		3/7/1895	71	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Farmer		owner		New Jersey		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Harry Peterson					Lillian Laurence				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address					
no		417 36 1621		Mrs. Mildred Peterson Chestertown, Md. RFD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>One year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 26, 1966</u> , to <u>Sept. 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug. 25, 1966</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Geza Koralewski</u>					22b. DATE SIGNED 9/15/66				
22c. PHYSICIAN'S NAME (Type) Geza Koralewski					22d. ADDRESS Millington, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		9/17/66		Baptist Cem.		Salem, N.J.			
24. FUNERAL DIRECTOR <u>Wills & Wills</u>					ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE SEP 19 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL CERTIFICATION

15838

15838

VR A15 (4)
15M 4-64

12849

12837

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kennedyville		c. LENGTH OF STAY IN 1b 87 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kennedyville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -----		d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida May Scotten		First Middle Last		4. DATE OF DEATH Month September Day 19 Year 1966	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 1, 1874		9. AGE (in years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Cecil Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Redmile		14. MOTHER'S MAIDEN NAME Rachel Bartley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-46-4660		17. INFORMANT Blanche Groves, Kennedyville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) QUE TO (c) QUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1966 , to Sept 19, 1966 , that (I) (we) last saw the deceased alive on Sept 19, 1966 , and that death occurred at 3:30 M, from the causes and on the date stated above.					
22a. SIGNATURE Robert W. Farr		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/20/66	
22c. PHYSICIAN'S NAME (Type) Robert W. Farr		22d. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23-66		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	
23d. LOCATION (City, town or county) Chestertown, Md.		(State)			
24. FUNERAL DIRECTOR Victor N. Kennedy		ADDRESS Still Pond, Md.		25a. REC'D BY REGISTRAR SEP 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

15281

15281

John W. Henry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12842 Item 1a Film 6300 9/21/66 mh											
12838											
1. PLACE OF DEATH a. COUNTY Kent MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) xxx/ 204 N. Queen St.						d. STREET ADDRESS Queen Street					
3. NAME OF DECEASED (Type or print) Margaret Anna Seney						4. DATE OF DEATH September 9, 1966					
5. SEX Female		6. COLOR OF RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1874		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Coppage						14. MOTHER'S MAIDEN NAME Eliza Jane McFadden					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Wm. D. Gould--Chestertown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardio-vascular disease IMMEDIATE CAUSE (a) 4221 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 64 , to 9/9 , 19 66 , that (I) (we) last saw the deceased alive on 9/9 , 19 66 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Farr						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/12/66			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS Chestertown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 12		23c. NAME OF CEMETERY OR CREMATORY Church Hill		23d. LOCATION (City, town or county) (State) Church Hill, Maryland					
24. FUNERAL DIRECTOR Edgar L. Lane						25a. REC'D BY REGISTRAR SEP 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Other please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prospect Park d. STREET ADDRESS 719 Prospect Rax Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Ira Short			4. DATE OF DEATH Sept. 5, 1966		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
5. SEX male			6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1890		9. AGE (In years last birthday) 76 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY USA		IF UNDER 1 YEAR: Months Days Hours Min.		
13. FATHER'S NAME Steven Short			14. MOTHER'S MAIDEN NAME Mary Prescott		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Gordon Short Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crownary thrombosis DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 9/5 , 1966, to 9/5 , 1966, that (I) (we) last saw the deceased alive on 7/5 1966, and that death occurred at 3A M, from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Farr			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) ROBERT W. FARR			22d. ADDRESS Chestertown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/66		23c. NAME OF CEMETERY OR CREMATORY Lawncroft Cem.		23d. LOCATION (City, town or county) (State) Linwood, Penna.					
24. FUNERAL DIRECTOR J. Wells Wells			ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR SEP 9 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

15823

15823

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

CHICAGO, ILLINOIS

RECEIVED

APRIL 15, 1954

FROM

DR. J. H. HARRIS

TO

DR. R. M. WATSON

RE

SYNTHESIS OF

2,4-DINITROPHENOL

FROM

2,4-DINITROBENZENE

AND

HYDROGEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12845					12840						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY KENT.					a. STATE MARYLAND b. COUNTY KENT. CO.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
R.F.D. Millington, Md					MILLINGTON, MARYLAND						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS						
AT-Home					R.F.D #1						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
Willis							STANLEY		SEPT. 30 1966		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE		COLORED		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7/5/1917		49 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTH PLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LABOR				VARIOUS				MARYLAND		U.S.A	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
DOUGLAS STANLEY						GERTRUDE BOWERS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
NO				216-18-2464		M.SS MARGARET Johnson				R.F.D. Millington, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of the lung										one day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Blood circulatory failure										2 days	
DUE TO (c) Cerebral hemorrhage										2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19				While at work		factory, street, office bldg., etc.)		(City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 30, 1964 to Sept. 30, 1966 , that (I) (we) last saw the deceased alive on Sept. 30, 1966 , and that death occurred at 10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
GEZA KORALEWSKI										OCT. 1. 66	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
GEZA KORALEWSKI										MILLINGTON, MD. 21657	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
BUR. AT			10/5/1966		ASHBURY CEMETERY			R.F.D. Millington, Md			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Kenneth Wally				Chesapeake, Md				OCT 5 1966		Charles Judge	

2011-12-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12846											
12841											
1. PLACE OF DEATH a. COUNTY <u>Keitt</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>49 hrs. 45 min</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suldersville</u>				d. STREET ADDRESS <u>17-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Keitt & Queen Anne's Hospital, Inc.</u>											
3. NAME OF DECEASED (Type or print) First <u>Medford</u> Middle <u>Cook</u> Last <u>Thompson</u>			4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>12/15/1894</u>			9. AGE (In years last birthday) <u>68</u>			10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Templeville Md.</u>		
13. FATHER'S NAME <u>William HARRY Thompson</u>						14. MOTHER'S MAIDEN NAME <u>Rachel Cook</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>214-32-6258</u>			17. INFORMANT <u>Hospital Record</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable infant myocardium</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4201</u> (c) <u>4201</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pop. H. = urinary retention</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-21</u> , 19 <u>66</u> , to <u>9-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-23</u> , 19 <u>66</u> , and that death occurred at <u>7</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>A.C. Dick</u>											
22b. DATE SIGNED <u>9-23-66</u>											
22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>											
22d. ADDRESS <u>Chestertown Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>SEPT. 27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUSIC CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>new BARCLAY MD.</u>		23e. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Edward Fellows Millington Md</u>											
25a. REC'D BY REGISTRAR <u>SEP 28 1966</u>											
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																							
1. PLACE OF DEATH a. CDUNTY <u>Kent County, Maryland</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>At Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Maryland</u> d. STREET ADDRESS <u>215 S. Queen Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
3. NAME OF DECEASED (Type or print) <u>Louise</u> <u>B.</u> <u>Yorker</u>			4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1966</u>		5. SEX <u>Female</u>			6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/31/1905</u>		9. AGE (In years last birthday) <u>61</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																					
Months	Days	Hours	Min.																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>												
13. FATHER'S NAME <u>Lewis Blake</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Hazelton</u>																		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-18-4526</u>		17. INFORMANT <u>Mr. Henry Rigby</u>			Address <u>215 S. Queen St. Chestertown, Md.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STROKE</u> <u>4221</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <table border="1"> <tr> <td> DUE TO <u>Arteriosclerotic cardiovascular disease</u> </td> <td> DUE TO (c) </td> </tr> </table>										DUE TO <u>Arteriosclerotic cardiovascular disease</u>	DUE TO (c)	<u>Several years</u>											
DUE TO <u>Arteriosclerotic cardiovascular disease</u>	DUE TO (c)																						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																
21. I certify that (I) (this hospital) attended the deceased from <u>9/6</u> , 19 <u>66</u> , to <u>9/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/24</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.																							
22a. SIGNATURE <u>Robert W. Farr</u>					22b. DATE SIGNED <u>9/27/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert W. Farr M.D.</u>																
22d. ADDRESS <u>Chestertown, Maryland</u>					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9/28/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Janes Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Chestertown, Maryland</u>															
24. FUNERAL DIRECTOR <u>Charles Judge</u>					25a. REC'D BY REGISTRAR <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																

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